

"A sensitive portrayal of the heart of family medicine...

and an accurate representation of the special challenges of family practice and the reasons for its recent renaissance."

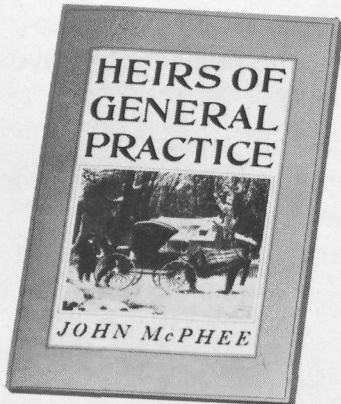
—JOHN P. GEYMAN, M.D., chairman, Department of Family Medicine, University of Washington; editor, *Journal of Family Practice*

"Using the case method so familiar to doctors, John McPhee has captured the essence of the struggle within medicine to find a better balance between humane interest in patients as persons and the scientific rigor demanded by modern medicine."

—ROBERT S. LAWRENCE, M.D., Charles S. Davidson Associate Professor of Medicine, Harvard Medical School

"McPhee has captured the beauty, as well as the complexity, of the interactions that occur between doctor and patient, and the family physician's special perspective."

—EDWARD J. SHAHADY, M.D., chairman, Department of Family Medicine, University of North Carolina at Chapel Hill



Paperbound, \$6.95, now at your bookstore, or use coupon or call this toll-free number to order:

800-638-3030

FARRAR, STRAUS & GIROUX, INC., Dept. JFP
P.O. Box 1541, Hagerstown, MD 21741

Please send me _____ copy(ies) of *Heirs of General Practice* (at \$6.95 each, plus \$1.50 postage and handling for the first book, 25¢ for each additional. If not satisfied, I may return book(s) postpaid within 10 days for full refund.

Enclosed is my check money order
Charge my VISA MasterCard

_____ Exp date _____

Signature _____

Name _____

Address _____

City _____ State _____ Zip _____
CA and NY residents, add sales tax.

LETTERS TO THE EDITOR

The Journal welcomes Letters to the Editor; if found suitable, they will be published as space allows. Letters should be typed double-spaced, should not exceed 400 words, and are subject to abridgment and other editorial changes in accordance with journal style.

BREAST FEEDING AND JAUNDICE

To the Editor:

In their article on breast feeding and jaundice (*Johnson CA, Lieberman B, Hassanein RE: The relationship of breast feeding to third-day bilirubin levels. J Fam Pract 1985; 20:147-152*), Drs. Johnson, Lieberman, and Hassanein came to the conclusion that "... breast-feeding infants ... have higher bilirubin levels than formula-fed infants on the third day of life. ..." I think this conclusion should be amended to include the following phrase: "when kept in the hospital until the third day."

Although I can only bring anecdotal evidence to bear on this question, I think a major flaw in their study is that a separate group of early discharged or not hospitalized patients was not included. I currently have a practice where 95 percent of my patients breast feed, most of them exclusively. Most of these patients were either born at home or were discharged early from the hospital at 12 to 24 hours of age. I find a significant difference (and again this is anecdotal) between these babies and babies left in the hospital for more than 24 hours as far as the ease in initiating breast feeding. The reason for this, I believe, is that hospital routines, even with rooming in, are not conducive to the initiation of good breast feeding.

As an example, nurses, as well meaning as they may be, cannot always bring the infant immediately when he or she is crying. This can

cause the infant to be frustrated and can result in some early feeding problems. Nurses in the nursery and nurses on the obstetric floor will often give conflicting or outdated advice, which also may interfere with successful lactation. I find that infants who spend less than 24 hours in the hospital have less weight loss, less nursing problems, and less problem with bilirubin on the third day of life.

I would wonder whether the authors of the article would have in fact found a significant difference between breast- and formula-fed infants had they included an early discharge or home delivery group in the statistics.

Gilbert L. Solomon, MD
Reseda, California

SOMATIZATION AND ALEXITHYMIA

To the Editor:

In Robert Smith's article, "A Clinical Approach to the Somatizing Patient" (*J Fam Pract 1985; 21:294-301*), a valuable concept was ignored in his discussion of this important issue. The last part of his article deals with countertransference in somatizing patients. This is an interesting concept from a psychiatric point of view, but it actually views the problem of somatization along an obsolete paradigm.

A more useful way of viewing the problem of the patient-physician relationship in somatization is through the concept of alexithymia¹ on the part of the patient rather than countertransference in the patient-physician relationship. In

Norgesic[®] Forte TABLETS

(orphenadrine citrate, 50 mg; aspirin, 770 mg; caffeine, 60 mg)

Stops the pain, not the patient.

Brief Summary

Indications:

1. Symptomatic relief of mild to moderate pain of acute musculo-skeletal disorders.
2. The orphenadrine component is indicated as an adjunct to rest, physical therapy, and other measures for the relief of discomfort associated with acute painful musculo-skeletal conditions.

The mode of action of orphenadrine has not been clearly identified, but may be related to its analgesic properties. Norgesic and Norgesic Forte do not directly relax tense skeletal muscles in man.

Contraindications:

Because of the mild anticholinergic effect of orphenadrine, Norgesic or Norgesic Forte should not be used in patients with glaucoma, pyloric or duodenal obstruction, achalasia, prostatic hypertrophy or obstructions at the bladder neck. Norgesic or Norgesic Forte is also contraindicated in patients with myasthenia gravis and in patients known to be sensitive to aspirin or caffeine.

The drug is contraindicated in patients who have demonstrated a previous hypersensitivity to the drug.

Warnings:

Norgesic Forte may impair the ability of the patient to engage in potentially hazardous activities such as operating machinery or driving a motor vehicle; ambulatory patients should therefore be cautioned accordingly.

Aspirin should be used with extreme caution in the presence of peptic ulcers and coagulation abnormalities.

Usage in Pregnancy:

Since safety of the use of this preparation in pregnancy, during lactation, or in the childbearing age has not been established, use of the drug in such patients requires that the potential benefits of the drug be weighed against its possible hazard to the mother and child.

Usage in Children:

The safe and effective use of this drug in children has not been established. Usage of this drug in children under 12 years of age is not recommended.

Precautions:

Confusion, anxiety and tremors have been reported in few patients receiving propoxyphene and orphenadrine concomitantly. As these symptoms may be simply due to an additive effect, reduction of dosage and/or discontinuation of one or both agents is recommended in such cases.

Safety of continuous long term therapy with Norgesic Forte has not been established; therefore, if Norgesic Forte is prescribed for prolonged use, periodic monitoring of blood, urine and liver function values is recommended.

Adverse Reactions:

Side effects of Norgesic or Norgesic Forte are those seen with aspirin and caffeine or those usually associated with mild anticholinergic agents. These may include tachycardia, palpitation, urinary hesitancy or retention, dry mouth, blurred vision, dilatation of the pupil, increased intraocular tension, weakness, nausea, vomiting, headache, dizziness, constipation, drowsiness and rarely, urticaria and other dermatoses. Infrequently an elderly patient may experience some degree of confusion. Mild central excitation and occasional hallucinations may be observed. These mild side effects can usually be eliminated by reduction in dosage. One case of aplastic anemia associated with the use of Norgesic has been reported. No causal relationship has been established. Rare G.I. hemorrhage due to aspirin content may be associated with the administration of Norgesic or Norgesic Forte. Some patients may experience transient episodes of light-headedness, dizziness or syncope.

Caution:

Federal law prohibits dispensing without prescription. NG-7

References: 1. Colket T, Mann LB: Electromyographic data presented at the following scientific meetings: American Academy of General Practice, Atlantic City, NJ, Apr 1964; American Academy for Cerebral Palsy, Dallas, Tex, Nov 1963; Loma Linda University School of Medicine, Scientific Assembly, Los Angeles, Calif, Alumni Postgraduate Convention, Mar 1964. 2. Masterson JH, White AE: Electromyographic validation of pain relief: Pilot study in orthopedic patients. *Am J Orthop* 1966;8:36-40. 3. Perkins JC: Orphenadrine citrate: Clinical and electromyographic controlled study in patients with low back pain. Data on file, Medical Department, Riker Laboratories, Inc. 4. Gold RH: Treatment of low back syndrome with oral orphenadrine citrate. *Curr Ther Res* 1976;23:271-276.

RK NF-1157

LETTERS TO THE EDITOR

some preliminary research in this area, it can be shown that a common problem in somatizing patients has to do with their degree of alexithymia, that is, their inability to verbalize affect and to elaborate fantasies. These patients are unable to state that they have depression, for instance, because they are unable to conceive of the notion. They do feel bad, however, and are able to present multiple symptoms to the physician, who is then frustrated that there are no objective physical findings.

A useful therapeutic approach based on this paradigm, then, is to attempt to "move away" from the patient's symptoms and to begin dealing with the historical and contextual events in the patient's life, as described by Katon (*Katon W: Somatization in primary care. J Fam Pract* 1985; 21:257-258), which are invariably present.

Joseph A. Troncale, MD
Department of Family Practice
University of South Alabama
Mobile, Alabama

Reference

1. Taylor, GJ: Alexithymia: Concept, measurement, and implications for treatment. *Am J Psychiatry* 1984; 6:141

The preceding letter was referred to Dr. Smith, who responds as follows:

While alexithymia is a fascinating concept of potential heuristic and descriptive value, a reliable and externally validated instrument to measure it has not been developed.¹ Although the lack of such an instrument does not distinguish alexithymia from most of the common somatizing disorders,² the latter are accepted in psychiatry and included in DSM-III. My reason for ignoring alexithymia is that the diagnosis of somatizing patients is already confusing to nonpsychiatrists, and to add another entity with little or no validation seems counterproductive. My point was in the opposite direction: to avoid diagnostic confusion by using a

simple descriptive term (common somatization syndrome) until more precise diagnostic entities can be reliably defined and validated and shown to be understandable and usable in primary care, where most of the patients are seen. Alexithymia, somatization disorder, hypochondriasis, and psychogenic pain may be useful constructs and are prime candidates for rigorous study, well exemplified in the work of Woodruff and associates.³ Until such study clarifies the diagnostic confusion, however, we can be content with the simple descriptive diagnosis (common somatizer) in primary care because the treatment for the various proposed diagnoses is essentially the same, always including a major emphasis upon the physician-patient relationship.

Dr. Troncale's assertion that countertransference is an obsolete concept is puzzling in view of the central role of the physician-patient relationship in managing somatizing patients. To focus upon the patient to the exclusion of countertransference overlooks many attitudes of physicians that can seriously interfere with developing a therapeutic relationship. Perhaps I have misunderstood Dr. Troncale because the reference he cites emphasizes the important role of countertransference and because, as I recommended, I agree with his final idea, ie, to avoid reinforcing somatization while attempting to shift the focus to stressful life events.

Dr. Robert C. Smith
Department of Medicine
College of Human Medicine
Michigan State University
East Lansing, Michigan

References

1. Lesser IM: A review of the alexithymia concept. *Psychosom Med* 1981; 43:531-543
2. Hyler SE, Sussman N: Somatoform disorders: Before and after DSM-III. *Hosp Community Psychiatry* 1984; 35: 469-478
3. Woodruff RA, Goodwin DW, Guze SB: *Psychiatric Diagnosis*. New York, Oxford University Press, 1974, pp 58-74